

UAB Division of Reproductive Endocrinology and Infertility

Oocyte Donor Personal History

Before being accepted as an egg donor at the University of Alabama at Birmingham Donor Oocyte Program, we need to learn some important information about your personal and medical history. Your responses to these questions will help us to make sure that your health and genetic make-up is compatible with the egg donation process, and that being an egg donor will not involve any special risks for you. This information will also help us in matching you to an appropriate recipient.

Please provide complete and accurate information to each of these questions. Your responses, and any other information you provide during the egg donation process, will be kept completely confidential. Information from this questionnaire may be made available **anonymously** to the recipient couple.

Date: ____/____/____

Name: _____

Address: _____

Home phone: (____) ____ - ____

Work phone: (____) ____ - ____

Social Security Number: ____ - ____ - ____

Please attach a recent photograph of yourself to this questionnaire.

**OOCYTE DONOR
MEDICAL AND GENETIC HISTORY**

**Oocyte Donation Program
The University of Alabama at Birmingham**

Date of Birth: ____/____/____ Occupation: _____

Race: _____ Religion: _____

Ancestry: _____

City, State and Country of Birth: _____

How did you hear about our program? _____

Have you ever been an egg donor previously at this or another program? YES NO

Physical Characteristics

Height: ____feet ____inches Weight: ____pounds

Eye color: _____ Hair color: _____ Complexion: _____

Hands: Left-handed Right-handed Ambidextrous

In what physical activities do you participate? _____

What manual skills do you have? _____

Personal Characteristics

How would you describe yourself? Please include a description of your personality and temperament: _____

What are your hobbies? _____

Describe any skills or talents you have: _____

What musical abilities do you have? _____

What is your favorite characteristic about yourself? _____

Why do you want to be an egg donor? _____

Tell us something about you that you would like for your oocyte recipient to know: _____

Medical History

Are you currently under a physician's care for any reason? YES NO

If yes, please explain: _____

Current medications (please include vitamins, aspirin, antacids, etc.)

<u>Medication</u>	<u>Frequency</u>	<u>Reason</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all allergies and your reaction to each:

<u>Medication</u>	<u>Reaction</u>
_____	_____
_____	_____
_____	_____

Do you wear eye glasses or contact lenses? _____

Do you smoke cigarettes? _____ How many/day? _____

Do you drink alcohol? _____ How many drinks/week? _____

Have you ever used I.V. drugs? _____ What kind? _____

How many sexual partners have you had in the past 6 months? _____

Have you had more than 10 sexual partners in your lifetime? _____

If sexually active, is your relationship mutually monogamous? _____

Menstrual History

Do you have regular, predictable menstrual periods? YES NO

How often do you have menstrual periods? Every _____ days

Have you ever had trouble getting pregnant? YES NO

If yes, please explain: _____

Contraceptive History

Please check all types of birth control methods used (past or present):

	<u>Method</u>	<u>Dates used</u>
_____	Birth control pills	_____
_____	I.U.D.	_____
_____	Condom	_____
_____	Diaphragm	_____
_____	Depo-Provera	_____
_____	Norplant	_____
_____	Rhythm Method	_____
_____	Other (_____)	_____

Pregnancy History

For all previous pregnancies (including abortions and miscarriages), please list the following information:

	<u>Year</u>	<u>Type Delivery</u>	<u>Outcome</u>	<u>Complications</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

Your Children

<u>Sex</u>	<u>Age (years)</u>	<u>Health Problems</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Surgical History

Please list the following information for any surgical procedure you have had (including appendectomy, laparoscopy, D & C, biopsies, tubal ligation, etc.).

<u>Date</u>	<u>Procedure</u>	<u>Reason</u>
_____	_____	_____
_____	_____	_____

Medical History

Please check any of the following medical problems you have now or have ever had:

Asthma	_____	Cancer	_____
Visual problems	_____	Birth defect	_____
Hormone problems	_____	Eating disorder	_____
High blood pressure	_____	Diabetes	_____
Blood clots	_____	Thyroid disease	_____
Heart disease	_____	Hepatitis	_____
Seizure disorder	_____	Mental disorder	_____
Sexually transmitted disease	_____ (type _____)		
Substance abuse	_____ (type _____)		

Other medical problems (please explain) _____

Personal Medical History

Please answer "Yes" or "No" to all of the following that you have experienced:

- | | |
|---------------------------------|---------------------------------|
| _____ Rash or hives | _____ Frequent urination |
| _____ Itching | _____ Waking to urinate |
| _____ Eczema | _____ Lumps |
| _____ Easy bleeding/bruising | _____ Anemia |
| _____ Constipation | _____ Diarrhea |
| _____ Lymph node/gland swelling | _____ Yellow jaundice/hepatitis |
| _____ Hearing loss | _____ Hernia |
| _____ Ringing in ears | _____ Eye problems |
| _____ Gall bladder problems | _____ Nosebleeds |
| _____ Sinus trouble, hay fever | _____ Arthritis, joint pain |
| _____ Dental/gum problems | _____ Swollen joints |
| _____ Heart murmurs | _____ Rheumatic fever |
| _____ Mitral valve prolapse | _____ Shortness of breath |
| _____ Neck pain | _____ Back pain |
| _____ Cough | _____ Headaches |
| _____ Chest colds, bronchitis | _____ Dizziness, fainting |
| _____ Depression | _____ Anxiety |
| _____ TB or exposure to TB | _____ Sleep disturbances |
| _____ Fevers, sweats, chills | _____ Sexual problems |

_____Pneumonia

_____Nervousness, tension

_____Genital warts

_____Swelling of feet/ankles

Other problems: _____

Immediate Family History

Are you adopted? YES NO

Please answer the following questions about your family members:

	<u>Mother</u>	<u>Father</u>	<u>Sister(s)</u>	<u>Brother(s)</u>
Age	_____	_____	_____	_____
Alive/Dead	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____
Age at death	_____	_____	_____	_____

Please check the blank of any relative who had had any of the following disorders:

	<u>Mother</u>	<u>Father</u>	<u>Sister(s)</u>	<u>Brother(s)</u>
Breast cancer	_____	_____	_____	_____
Uterine cancer	_____	_____	_____	_____
Other cancer	_____	_____	_____	_____
Thyroid disease	_____	_____	_____	_____
Heart disease	_____	_____	_____	_____
Blood clots	_____	_____	_____	_____
Infertility	_____	_____	_____	_____
Birth defects	_____	_____	_____	_____
Other	_____	_____	_____	_____

Comments: _____

Family History

Please answer "Yes" or "No" if anyone in your family his ever had any of the following conditions:

- Down's syndrome (mongolism) _____
- Cleft lip or cleft palate _____
- Congenital heart disease _____
- Pyloric stenosis _____
- Neural tube defects _____
- Diabetes _____
- Mental disorder _____
- Cystic fibrosis _____
- Hemophilia _____
- Mental retardation _____
- Seizure disorder _____
- Muscular dystrophy _____
- Deafness before age 60 _____
- Blindness in both eyes before 60 _____
- Cataracts before age 40 _____
- Schizophrenia/manic depression _____
- Birth defect _____
- Huntington's disease _____
- Spina bifida (open spine) _____
- Congenital heart defect _____
- Two or more miscarriages _____
- Two or more stillbirths _____
- Tuberous sclerosis _____
- Polycystic kidney disease _____
- Progressive kidney disease _____

Neurofibromatosis _____
Early death/heart attack _____
Same cancer in more than one family member _____
Severe bleeding tendency _____
Color blindness _____

Family History (continued)

Hyperlipidemia _____
Short stature (<4'10") _____
Skeletal abnormality _____
Metabolic diseases _____
Retinitis pigmentosa _____
Multiple polyposis of the colon _____
Marphan syndrome _____
Retinoblastoma _____
Alport disease _____
Congenital hip dislocation _____
Clubfoot _____
Cleft lip or palate _____
Hypospadias _____
Albinism _____
Rheumatoid arthritis _____
Severe refractive disorder _____
Hemoglobin disorder _____
G6PD deficiency _____

Maternal (Mother's) Ancestry

Please check the blank of any relative who has had any of the following disorders:

	<u>Grandmother</u>	<u>Grandfather</u>	<u>Aunt</u>	<u>Uncle</u>
Breast cancer	_____	_____	_____	_____
Uterine cancer	_____	_____	_____	_____
Other cancer	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Thyroid disease	_____	_____	_____	_____
Heart disease	_____	_____	_____	_____
Blood clots	_____	_____	_____	_____
Infertility	_____	_____	_____	_____
Birth defects	_____	_____	_____	_____
Other	_____	_____	_____	_____

Paternal (Father's) Ancestry

Please check the blank of any relative who has had any of the following disorders:

	<u>Grandmother</u>	<u>Grandfather</u>	<u>Aunt</u>	<u>Uncle</u>
Breast cancer	_____	_____	_____	_____
Uterine cancer	_____	_____	_____	_____
Other cancer	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Thyroid disease	_____	_____	_____	_____
Heart disease	_____	_____	_____	_____
Blood clots	_____	_____	_____	_____
Infertility	_____	_____	_____	_____
Birth defects	_____	_____	_____	_____
Other	_____	_____	_____	_____

Additional Information

Employer: _____

Occupation: _____

Duration of employment: _____

Health insurance carrier: _____

Policy holder: _____

Group #: _____

Emergency contact: _____

Relationship: _____

Phone numbers: (_____) _____ - _____ (_____) _____ - _____

Nearest relative or close friend not living in same residence:

Name: _____

Relationship: _____

Phone numbers: (_____) _____ - _____ (_____) _____ - _____

To the best of my knowledge, all of the information given in this questionnaire is true and complete, and I have included all relevant information.

Oocyte Donor Applicant

Witness

_____/_____/_____
Date